Issue 9 September 2004

network

SMMGP SUBSTANCE MISUSE MANAGEMENT IN GENERAL PRACTICE

A national newsletter on substance misuse management in primary care

New GP Contract- what *you* think

Questionnaire responses - vexed, perplexed and delighted

GPs whilst still unsure about the full impact of the new GMS contract, have given some encouraging responses. Of the 200 of you who responded to last edition's survey, a majority of GPs believe the new GMS contract will lead to an increase or maintenance of drug treatment in primary care. A third (32%) of our readers believe it will lead to an increase in local treatment for drug users in primary care, while 37% believe it will lead to no change.

Network

Features

Regulars

www.smmgp.co.uk

However, the SMMGP survey reveals a lingering anxiety among our readers about the contract. 31% believe the nGMS will result in a decrease in the number of practices prepared to treat drug dependency locally. Possible indications of this can also be seen in the initial reaction to the contract among practices. Although early days, when asked whether the new contract had lead to an actual change in the number of practices prepared to treat drug dependency locally, 29% of you reported reductions compared to 8% reporting an increase, while 63% reported no change. 16% reported an increase in primary care investment, 73% reported no change, and 11% reported an increase in secondary care investment - respondents did not indicate any alarming shift in the balance of resources from secondary care to primary care.

NTA new contract survey responses

GP anxiety about the nGMS is somewhat counterbalanced by an NTA regional survey of commissioners (May 2004) on the impact of the contract. A total of 117 practices in England will start to treat drug users over the coming financial year. Whilst the NTA believe the new GMS contract has not affected the trend of increased GP involvement, the NTA survey showed four GP practices in England stopping provision of treatment for drug users as a result of the new contract. The NTA believe there are no grounds for complacency as such practices still have the potential to have a negative impact upon neighbouring practices and increase the burden on local specialist services. The NTA survey found that almost every DAT area was planning to maintain the financial status quo through Local Enhanced Services (LES) specifications with the majority of GP payment funding coming from DAT pooled treatment budgets. There were only four examples given of PCTs providing part-funding although a further three were currently exploring this option and another exploring PMS funding.

Local commissioners are meeting the nGMS with a variety of responses. There is strong support for local commissioning with 42% reporting locally enhanced services (LES) compared to 22% nationally enhanced service (NES) arrangements, while 10% had both NES and LES and 24% had other arrangements in place.

The SMMGP and NTA findings reveal some mixed but encouraging response regarding the new contract among primary care teams. Chris Ford GP Adviser for SMMGP and advisory editor for Network said "The nGMS contract is here to stay and we must ensure that we try to use it as positively as we can. If you have questions or uncertainties share them with us; and if you are having trouble writing that service level agreement ask as well, In this issue we give an example of one area (Oldham) that has gone for a mixed NES/LES package. Future issues will look at LES only NES only responses."

news digest · news digest

Latest Shipman Inquiry recommends changes to prescribing practices

The inquiry looking into how Harold Shipman was able to obtain controlled drugs has called for tighter controls on their prescription, supply and destruction.

Dame Janet Smith, Chairman of the Inquiry proposes the establishment of a single multidisciplinary drugs inspectorate to replace the three existing drugs inspectorates. This will monitor and audit the supply, prescription, storage, distribution and disposal of controlled drugs by doctors and other health care professionals.

The report points to instances where both individuals and the systems in place to monitor the prescription of controlled drugs failed to identify and stop Shipman from killing patients. It recommends the introduction of special forms for both private and NHS prescriptions and recording the identity of persons collecting controlled drugs from a pharmacy. It also wants stricter rules around the collection and disposal of such drugs.

Other recommendations include making it a criminal offence for doctors to prescribe drugs for themselves, as Shipman did when addicted to pethidine in the 1970s.

The report admonished the Home Office and the General Medical Council for not restricting Shipman's ability to possess and prescribe controlled drugs after he was convicted of dishonestly obtaining pethidine in 1976 while working as a GP in Todmorden, West Yorkshire.

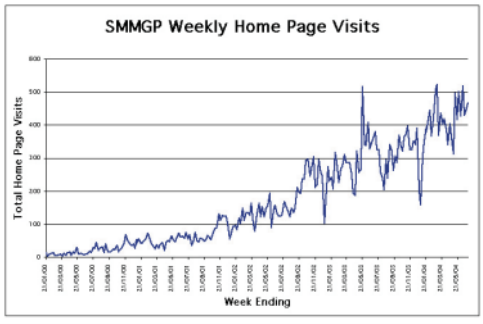
Responding to the report, Home Office Minister, Caroline Flint said, 'These are very significant recommendations with fundamental implications for the use of controlled drugs in the NHS and elsewhere.'

'We will need to study them carefully and in consultation with existing inspectorates, patients, NHS and police organisations, and the healthcare professions.'

She added that decisions on some issues could not be made until the inquiry's fifth report into the monitoring and regulation of doctors is published. This is expected in late autumn.

SMMGP website a hit

In mid July the SMMGP website had its 40,000 visitor. The website is reaching out to more and more practitioners, with over 450 hits a week and 577 registered members.



The site is building on success and features a host of documents, summaries, hints and discussion. New on the site are opportunities for users to join in discussions, plus useful documents, such as *The Black Market in Methadone - Some Reflections, Framework for a New Community Pharmacy Contract (PhS)* and the latest CJIP information sheets. To find out how the site can help you visit www.smmgp.co.uk

Drug Certificate proves popular with GPs


I, The Project Director of the
Drug Misuse Training Programme

declare that:

.....

has been awarded the

Certificate in the Management of Drug Misuse Part 1
of the Royal College of General Practitioners

On 8th July 2004

Signed

Clare Gerada
MBBS, MRCPsych, FRCGP, MBE

Over two hundred GPs had completed at least one module of Part One of the Certificate in the Management of Drug Misuse within the first two weeks. As of the end of August a total of 599 GPs have completed the harm reduction module and 548 GPs have passed. 392 GPs have taken the treatment module and 374 have passed. GPs are signing up for the RCGP national face-to-face training and local events are being organized by providers around the country. The large number attests to the interest GPs have in drugs misuse training and the increasing popularity of e-learning. The e-module training works well because it is not only a 'non-threatening' way of learning but it can reach out to new audiences.

Currently, e-learning is only available to GPs. There is a group developing an appropriate Part One equivalent for nurses. Pharmacists already have an equivalent post graduate pharmaceutical education. The open learning/distance Learning package has been available for about 10 years and has been updated twice. It is currently undergoing review with input from the RCGP National Drug Misuse Training Programme.

The Certificate Part One was launched in May at the 9th National Conference 'Management of Drug Users in Primary Care'. It is aimed at improving the skills of the generalist and consists of two stages, 1) Two modules of electronic learning which are completed via the doctors.net.uk website and 2) Six hours of face-to-face training organised on a local or regional basis. This contains a set of core competencies and will equip GPs to be able to offer Nationally or Locally Enhanced Services for drug users.

For further information about the course visit:
www.rcgp.org.uk/drug/certificate.asp or
www.smmgp.co.uk
To complete the e-modules visit www.doctors.net.uk

Part 2 of RCGP Certificate being revamped

The Certificate Part Two is being fully revamped following the success of Part One. Part Two has been running for three years and until the introduction of the Certificate Part One has catered for a wide range of skill levels.

Since the development of the certificate in 2001 there have been a number of changes in primary care and the review will refine the existing course materials in line with the needs of Drug and Alcohol National Occupational Standards (DANOS), CPD and NTA Models of Care. This will also allow time for people to complete the Certificate Part One or equivalent training first.

The next Part 2 course will begin in spring 2005, for more information visit www.rcgp.org.uk or e-mail the team at drugmisuse-enquires@rcgp.org.uk

news digest continued on page 7

Under contract

Part I: How one PCT is responding to the nGMS contract by offering both Local and National Enhanced Services

No longer 'new', the GMS contract is well and truly here. We take a look behind the scenes to find out how a leading PCT is combining both NES and LES to provide the best in care for them and their patients.

Oldham Substance Misuse Service (OSMS) has a long history of working with GPs in Primary Care. Like all areas, the new GMS contract posed a challenge and they had to come up with a good system.

This task fell at the feet of the Shared Care Monitoring Group. This monitors the level of care in the area and is made up of local GPs, representatives from the OSMS, the Drug and Alcohol Action Team (DAAT) and the local consultant for drugs and alcohol. Together they looked at the growing issue of 'national' enhanced services (NES) versus 'local' enhanced services (LES) and came to the conclusion that both can be offered in Oldham.

Currently Oldham offers Shared Care Clinics in 25 of their 46 (54%) surgeries, which exceeds the NTA targets for 2003/4. They have two 'second level' clinics and 19 clients suitable for shared care, but also have non-prescribing GPs whose patients receive prescriptions from a 'second-level' GP surgery. Their general medical care remains the responsibility of their own GP.

Table 1 outlines the range and benefit of both systems. The local enhanced clinics will ensure that the high standard of care already offered to this client group in Oldham will continue and also allows GP's to work towards a NES if they too wish.

Table 1. Shared care prescribing for drug misusers: format for participating national and local enhanced services

NATIONAL ENHANCED	LOCAL ENHANCED
1. Keep a register of patients 2. Effective liaison with shared care worker 3. Arrangements for regular reviews by doctor 4. Liaison with core SMS, non-statutory agencies, child protection and mental health.	1. Keep a register of patients 2. Effective liaison with shared care worker 3. Arrangements for regular reviews by doctor
1. The lead GP for the service should demonstrate training to the minimum level of the RCGP Certificate in Drug Misuse (part 2). 2. Attend at least two days relevant training. Update events every year.	1. Dr to make a commitment to completing the RCGP Certificate in Drug Misuse (part 1) within the first six months of commencing service. 2. To attend at least one clinically focused local training update event each successive year.
1. Written agreement to prescribe only in accordance with locally agreed shared care guidelines.	1. Written agreement to prescribe only in accordance with locally agreed shared care guidelines.
1. Be responsible for safety and training of clinical and non-clinical staff.	
1. Be prepared to look after patients of other practices, where locally agreed.	
Be able to: a) assess drug use, using urine screening b) treat complications (eg infections) c) test for BBV including HIV(Hep C if pre and post test counselling available) d) offer Hep B inoculation e) have an up to date knowledge of different pharmaceutical and non-pharmaceutical treatments for drug misusers f) provide drug information to users and families g) provide harm reduction advice to users and families.	Be able to in collaboration with liaison drug worker: a) assess drug use, using urine screening b) treat complications (e.g. infections) c) test for BBV including HIV(Hep C testing if pre and post test counselling available) d) offer Hep B inoculation e) provide drug information to users and families f) provide harm reduction advice to users and families.
Carry out annual audit of: a) attendance, drop outs, etc (Must state) b) outcomes c) prescribing d) Hep B screening / immunisation.	Carry out annual audit of: a) attendance, drop outs, etc (Must state) b) outcomes c) prescribing d) Hep B screening / immunisation
Payment: £1,000 retainer £350 / patient / year	Payment : £500 retainer £200 / patient / year

Are you involved in an LES or NES? Parts II and III of 'Under contract' can feature your service, team, or area's experiences in providing Local or National Enhanced Services as part of the GMS contract. If you think your service has what it takes or is missing the mark contact Mark@smmgp2.demon.co.uk

What is treatment?

The fact that we have to ask what drug and alcohol treatment is implies that somehow treatment for substance misusers is distinctly different to that for mainstream patients. In many ways it is not. Gordon Morse explains what substance misuse treatment should mean for GPs and their patients.

GPs are experts at understanding their patients – understanding their pathology, but also understanding the person that contains that pathology, and how it will affect their lives and their feelings. We negotiate with the whole spectrum of human personalities every day.

Every ten minutes we ascertain what is making a patient feel unwell, and what strategies we can employ to make them feel better and reduce the harm from their condition. Do not take for granted what we do. It is profoundly complex and highly skilful. **Regrettably, evidence-based guidelines tend to seek to simplify this process by making the person irrelevant – a major problem perhaps of modern medicine.**

Inside a user's head

Substance misusers are like all other patients in many ways. GPs still need to ascertain what their motives are for seeking our help and to help them feel better and reduce any harm. However, with the substance misuser, we are effectively treating two people. **Inside the heads of most substance misusers is an internal dialogue between the negative, denying, self-destructive self, and the positive, motivated and health seeking self.** Throughout the duration of the patient's habit, the balance of power between these two selves tends to fluctuate.

Our task is to encourage and give optimism to the positive self, while being honest and establishing trust with the negative. It is a slow and gentle exercise, reinforcing the healthy attitudes and building trust. The harm reduction targets are easily achieved with someone in whom survival and recovery is dominant – but very often it is the addictive self that is tipping the scales. We need to explore why this is so. There are often powerful social factors at play such as cliques of substance-using friends, gangs, or most significantly, a using partner.

For some, the drug using culture is a successful career. For many there will be a long history of harm and failed attempts at recovery, which can lead to a profound demoralisation where nothing can change.

For others we must remember that drug using is enjoyable, and feel drug using is necessary to blot out the memories of abuse and sadness.

Optimism

Treatment therefore is about doing and listening – we do all the harm reduction 'stuff' but we listen for the cues that each individual is drawn back into using by. We can help to cognitively re-frame some of these confounding factors through their own health-seeking eyes. And we must maintain a sense of real optimism that change and recovery are possible. The ill-informed public often think drug using is an act of cowardice, but in the recovering addict, I have encountered countless acts of heroism.

Dr Gordon Morse

What we want from treatment from our GPs

Too often the wishes of a drug user are ignored or mistrusted. Alan Joyce, a recipient of drug treatment and senior advocate at the Alliance, explains why this is 'bad medicine' and how primary care staff can improve the care and health of substance users.

No one individual can claim to know what drug users want. To claim this would not only be presumptuous but also perpetuate the idea that we are a homogeneous group with identical problems, needs, and expectations of what we want from our GPs.

The evidence base on what users want is unfortunately poor and reflects the fact that drug users, historically, have been seen as the recipients of treatment rather than as informed consumers of care, capable of determining with a supportive GP the kind of care that best meets their needs.

It is tempting to say that we want is a script, or perhaps a more sophisticated variant of the same such as diamorphine on demand. Obvious as it may seem, this misses the point. Getting the script right is important, particularly to those of us who use opiates. Being forced into detoxification or being given sub-optimal doses of substitute medication is not only unhelpful, but bad medicine based on opinion rather than evidence.

But we also want care and treatment for the whole range of health and social problems that we might experience, including blood borne virus infections, smoking and alcohol problems, poor diets, mental health difficulties, health problems associated with social exclusion, poor housing and poverty and advice on harm reduction and health promotion.

In many respects these needs are not so different to the problems of the non-drug using patient. Many of them can and are managed very effectively within general practice although some may require onward referral to a specialist.

As the Clinical Guidelines say '…drug misusers have the same entitlement as other patients to the services provided by the National Health Service. It is the responsibility of all doctors to provide care for both the general health needs and drug related problems, whether or not the patient is ready to withdraw from drugs.' [1]

The General Medical Council is equally clear on this issue, 'no-one should be discriminated against because of their ability to pay, their social position, their health status, their race, religion, sex, lifestyle or their age. Indeed, those whose needs are greatest, for whatever reason, even if their illnesses are to some extent self inflicted, have the same rights as anyone else and if equity is to be respected they may well require a greater share of the available resources to maintain life or restore health' [2]

Drug users are individual human beings

Therefore to answer the question, what we want from treatment, is that we want just what any other patient would from their GPs – good quality general health care and non judgemental, evidence-led treatment for their specific chronic relapsing medical conditions.

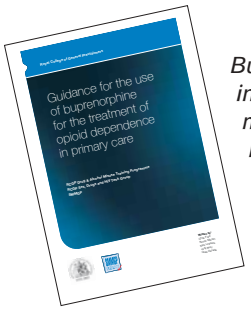
Above all, I would suggest that what we need and want is to be treated with empathy. Any GP who is able to set out on a path that is illuminated by this beacon will be on the path to a positive and rewarding treatment outcome for both themselves and their drug using patient.

Alan Joyce, Senior Advocate the Alliance

References

1. Department of Health, The Scottish Office Department of Health, Welsh Office, Department of Health and Social Services, Northern Ireland (1999) Drug Misuse and Dependence – Guidelines on Clinical Management. London: The Stationery Office. www.drugs.gov.uk/polguide.htm);
2. General Medical Council (2003) Priorities and Choices: section 2 Duties of Care General Medical Council, London

Buprenorphine maintenance prescribing – the evidence speaks for itself



Buprenorphine seems to have settled into English drug treatment practice mainly as a detoxification drug. But many practitioners are less familiar with its use as a maintenance drug. Chris Ford and Nick Lintzeris present evidence for its effective use.

Worldwide the value of maintenance prescribing for opioid dependency is well established (Mattick *et al* 2002). This is usually with methadone but buprenorphine definitely has a place. But why buprenorphine has become increasingly popular especially for detoxification is up for debate. It may be down to the lack of a good alternative or because of a reluctance to still value maintenance prescribing in treatment. Methadone ***reduction*** is still the most common treatment modality in UK practice.

The daily dose range of buprenorphine maintenance prescribing is 8-32mgs. The most common range for achieving abstinence from concurrent heroin use is 12-24 mgs a day. Because buprenorphine is a partial agonist, higher doses may not produce corresponding increases in effects. Increasing the dose therefore may not make any difference in subjective effects (for example, increased euphoria) but may further reduce illicit opioid use by increasing the blockade effect.

Gold standard

A Cochrane review of a range of databases found thirteen randomised controlled trials (RCTs) on maintenance, all but one of which were double-blind (Mattick, et al 2002). They evaluated the effects of buprenorphine maintenance against placebo and methadone maintenance in retaining patients in treatment and in suppressing illicit drug use. A meta-analysis found the following results:

- Buprenorphine can achieve broadly comparable outcomes with average / commonly prescribed methadone doses currently used in the UK (30-60mgs). Specifically, buprenorphine given in flexible doses is statistically less effective than methadone in retaining patients in treatment. There is a trend however (not significant) for less heroin use in buprenorphine groups compared with methadone groups.
- Optimal doses of methadone (for example 80-120mgs) are still the gold standard for maintenance.
- The efficacy of high dose buprenorphine (16-32mgs) compared with higher dose methadone (80-120mgs) has not so far been examined in comparative studies.

The reviewers conclude that buprenorphine is effective in maintenance treatment for heroin dependency, but it is not more effective than methadone at adequate dosages.

In addition, buprenorphine is no different to methadone in tackling other substance use (such as cocaine, benzodiazepines or alcohol).

Consensus

There are other important factors to consider when choosing between methadone and buprenorphine (Doran *et al* 2003). For example, there is nothing yet to suggest which drug works best with particular subgroups, with each case having to be judged on individual merit, after careful consultation with the patient.

There is increasing consensus, however, among clinicians experienced in using both buprenorphine and methadone in maintenance that:

- Buprenorphine may be better suited to those who wish to cease using heroin completely, as the blockade effects of even moderate dose buprenorphine interfere with the subjective effects of additional heroin use.
- Buprenorphine is less sedating than methadone. This may be positive or negative for different patients.
- Buprenorphine is safer in overdose.

Optimal outcomes with buprenorphine maintenance will occur when a range of other non-pharmacological interventions, such as counselling, support the prescribing of buprenorphine.

Dr Chris Ford and Dr Nick Lintzeris

Adapted from the second edition of 'Guidance for the use of buprenorphine for the treatment of opioid dependence in primary care' (Ford 2004). Available from Mark Birtwistle SMMGP or download from www.smmgp.co.uk

References

Ford, C. (2004) *Guidance for the use of buprenorphine for the treatment of opioid dependence in primary care,* 2nd edition. London: RCGP & SMMGP.

Mattick, R.P., Kimber, J., Breen, C. and Davoli, M. (2002) Buprenorphine maintenance versus placebo or methadone maintenance for opioid dependence (Cochrane Review). In: *The Cochrane Library,* Issue 2, Oxford: Update Software.

Doran ,C. M., Shanahan, M., Mattick, R. P., Ali, R., White, J. and Bell, J. (2003) Buprenorphine versus methadone maintenance: a cost-effectiveness analysis. *Drug and Alcohol Dependence,* 2003, 71(3), p.295-302.

Pharmacy Fix

Should buprenorphine tablets be crushed?

Continuing our page dedicated to pharmacy issues, we ask the big question surrounding buprenorphine administration. Should you crush it? ? Ms Anshu Hinton, Principal Pharmacist, Substance Misuse Service for the Central and North West London Mental Health NHS Trust gives her view.

Inadequate buprenorphine supervision can result in diversion to the black market or inappropriate use of the drug, such as crushing in order to inject. Buprenorphine is a sublingual tablet and usually takes five-to-ten minutes to dissolve. This makes it a difficult drug to supervise. The first three minutes are the most important. During this time the tablets will start to dissolve, making it less suitable for resale or injection.

A recent letter in *Drug and Alcohol Review* discussed the crushing of buprenorphine tablets for patients suspected of diverting the drug (Muhleisen *et al* 2003). The authors describe how they crush high-dose buprenorphine (8mg or more) as part of a supervised dosing programme. Though it does not stop diversion or injecting, the authors note it helps reduce the opportunity to do so.

Reducing the overall effect

No studies examine the effects of crushing the tablets prior to administration. Manufacturer Schering-Plough states that this should not affect the absorption of buprenorphine, but will increase the surface area making it dissolve more quickly. They note that this may result in the production of excess saliva, which in turn may increase the chance of swallowing unabsorbed drug, thereby possibly slightly reducing its overall effect.

Muhleisen and colleagues report that daily average doses showed no significant changes as a result of crushing. They advise that the possibility of swallowing or inhaling powder can be minimised by lightly crushing or breaking the tablets into a granular consistency

In my opinion, crushing prior to administration should only be carried out in exceptional circumstances. The first is when patients are non-compliant and suspected of diverting – such as in a community setting, in prisons or within specialist substance misuse services. The second is when there is a requirement to lessen time for observation, for example in a busy community pharmacy.

Health risks

It is important to consider the additional time and possible cost involved in crushing the drug. This may also have an impact on patient capacity, compromising the number of patients who can be dispensed safely. It is also important to consider the health risks of injecting crushed buprenorphine with mouth flora and saliva. **On a more serious note, buprenorphine is not licensed if crushed, even if it is covered by a signed protocol. In addition, before embarking on "crushing" pharmacists should check that their indemnity insurance covers this activity.** ***[Ed. Ideally seek employing authority agreement as protection from liability is reduced]***

Overall, I feel that the tablets should only be crushed when there is a valid clinical reason, and the prescriber is willing to take on clinical responsibility for this unlicensed administration. In addition it is essential to ensure that the patient understands and consents to the administration of crushed buprenorphine.

This is the second article on our new Pharmacy Fixit. We welcome contributions and comments from all pharmacist readers of Network.

References

Muhleisen, P., Spence, J. and Nielsen, S. (2003) Crushing buprenorphine tablets. *Drug and Alcohol Review,* 22(4): 471-2.

'Crushing', whilst not unlawful, is contentious and can reduce your protection from liability

How can I join the local shared care scheme?

Dear Pharmacy Fixit

I am really keen to support the local shared care scheme for prescribing to drug users. I already undertake supervised consumption with 23 patients on methadone and enjoy this work. I am now being asked more frequently to provide this service for patients starting on buprenorphine. My local PCT has decided to only pay a nominal dispensing fee for buprenorphine supervision, much less than methadone. What should I do?

Pharmacy Fixit says,

I would suggest you contact your Local Pharmaceutical Committee (LPC) Secretary and explain the problem. They may be able to negotiate a better arrangement.

Also write to your DAT quoting the benefits of supervised buprenorphine reduction in preventing diversion. A recent French paper shows the benefits of giving patients daily supervised supplies from a pharmacy and how it helps prevent diversion (Auriacombe 1997). I would seek support from the prescribers , who can write to the LPC and provide back-up information.

You could also ask your PCT to look at their public health budget to fund this and offer to do it on a pilot basis from their slippage money.

You could always move the pharmacy to another PCT! And if all else fails - wait for the new contract and hope it is included.

Answer provided by Martin Bennett, Pharmacist on SMMGP Advisory Group

References

Auriacombe, M. and Tignol, J. (1997) 'Buprenorphine use in France quality of life and conditions for treatment success.' *Research and Clinical Forums,* 1925-32.

Join PharMAG and receive PharMAGazine- see page 11

Spotlight on Adfam – listening to the families of substance users

Adfam is a national organisation dedicated to the needs of families affected by drugs and alcohol. We are also a leading provider and promoter of effective substance-related family work.

Our focus is unapologetically on the family and not the user. Families are usually the first to suffer from an individual's substance misuse. Not only do they suffer the anxiety about their relative's health, they also have to deal with the practical problems an often chaotic lifestyle can create.

Family members often have to cope with financial burdens such as dealing with social services on the user's behalf. Families also have to handle extreme problems such as theft from the family home or violent and abusive behaviour.

Adfam uses 'family' to include partners and friends as well as siblings, parents and grandparent. Our strength lies in taking a wider view of substance misuse. We need to move away from a traditional view of drug using families as parents with teenage children and to resist pigeonholing drugs as a criminal justice issue. Drugs, like alcohol and cigarettes, must also be addressed as a health and social care issue.

Adfam offers videos and publications to families and groups, training and direct support work (in London-based prisons). Our services will expand as funding permits and in the meantime we consult or collaborate with other voluntary and statutory organisations, family and drug agencies and government departments to ensure families' needs are heeded.

Adfam was established by the mother of a heroin addict who could not find support. Despite the efforts by local voluntary support groups, there is still much to do in the area of family care. Adfam is working tirelessly to help address families' requirements and we are campaigning to improve the level and consistency of care across the country. Adfam's web-based database of local groups signposts families to helplines and groups that can offer information and support they might need.

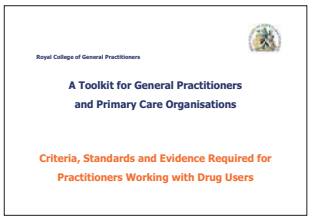
From our community engagement work, we know that fear and isolation are some of the biggest problems a user and their family can face. The chance and courage to speak up is not always easy to find – especially if a family is living with the practical and emotional pressures of a relative's drug use. Adfam gives a voice to families as often and in as many ways as possible. Adfam is there to help family members see they are not alone.

We want Adfam's reputation to continue to spread, especially among health practitioners. Specialist as well as primary care workers are encouraged to pass on our information resources as an additional source of help. Families need to be encouraged to find support for themselves and not just to be seen as an extension of, or route to, the user.

For more information please log-on to www.adfam.org.uk

news digest *(continued from page 2)*

RCGP launch toolkit for practitioners working with drug users



The RCGP has developed a toolkit for generalists working with drug users to run alongside the Certificate mentioned on page 2. The toolkit has been produced in response to GPs and service commissioners seeking information and guidance with respect to the competencies, skills, qualifications, and ongoing personal development needs of practitioners.

The toolkit has been well received and there is evidence that it is being used alongside the commissioning process for individuals, DATs and PCTs.

The toolkit aims to map skills and competencies not only to the tier of service that a practitioner might find themselves working in, but also provides guidance regarding the service environment that a practitioner should be working within.

Feedback...

We welcome feedback on the use of the toolkit in practice and this will be used in future revisions of the toolkit. We are particularly interested in receiving the views from GPs who are using it in supporting the development of their personal learning portfolios and in the specialist element of their appraisal. It is hoped that such feedback will influence decisions in guidance around the revalidation of GPs with a special interest in this area. Further information about the toolkit can be obtained from:

Dr Linda Harris, Wakefield Integrated Substance Misuse Service, c/o Turning Point, Grosvenor House, 8-20 Union Street, Wakefield WF1 3AE

NICE – next wave take on methadone and buprenorphine

Current opioid substitution therapies are to be evaluated by the National Institute for Clinical Excellence (NICE).

The tenth wave of the work programme for NICE will look into the effectiveness and cost-effectiveness of oral methadone and sublingual buprenorphine as substitute opiates for the management of opiate misusers and to identify those groups of drug misusers (in the community and prison settings) who are most likely to benefit from being prescribed oral methadone and those most likely to benefit from sublingual buprenorphine. They are also to advise on the optimum doses and context of care required to secure effective outcomes.

Jane Hutt, Minister for Health and Social Services said, 'Drug misuse is a growing problem [...] so it is good news that NICE will be providing guidance. This will bring benefits not just to the NHS but to wider communities as a whole'. Their findings are not expected until autumn 2006.

If you would like to be involved in the review process, you can register as a stakeholder on NICE's website: www.nice.org.uk

Cultural considerations – improving community involvement

The number of British Asians presenting to drug services is going up, particularly in London. Heroin and crack use is also prevalent among these communities (Bashford et al 2003). But what is being done to meet the needs of these and other minority ethnic clients? Jeff Fernandes from Islington PCT looks at the case of young Asian heroin smokers presenting to his service. The example reveals some important considerations for making a service reach out and work with different cultures.

At the Margerete Centre in London we explored the needs of Bengalis and Muslims presenting to the service with drug problems. What we found altered our perception of the service.

Not only were there significant differences in use patterns and related needs, the service was also underachieving in their care.

Different routes

In particular we found a marked difference in routes of administration of the Asian group compared to the 'White British' group. All Asians who presented to the centre, chased and smoked heroin and had no history of injecting. For white users, the majority injected and had a history of injecting on average between 5 to 7 years. In percentage figures this was applicable to 93% of white/European users.

The length of drug history for Asians was also shorter. Typically an Asian service users had been using on average for three years. For white/European service users this was 10.4 years with a period of initially smoking/chasing heroin of one year.

White UK/European are also more likely to be more prone to polydrug use. Almost all (95%) of this group have an injecting history of a minimum of three years, with 90% using heroin, crack, benzodiazepines and alcohol routinely – indicating they are poly drug users.

For people who described themselves as Asian, all were smokers and had been smoking for two years on average. The main drug of choice was heroin. They did not use alcohol or benzodiapines, though they did tend to use crack occasionally (such as once a week).

Inappropriate detox

With a small drugs history and uncomplicated drug presentations, many of the clients from the Bengali community requested an outpatient detoxification regime. From the users point of view this was a quick and easy way of getting 'clean'.

From a clinicians' point of view, uncomplicated drug profiles and small drug histories seemingly make the Asian clients suitable for an outpatient detoxification programme. There was a general consensus for trying to catch their 'habit early' and therefore detoxifying this cohort of clients before their habit had become more ingrained and problematic.
This reasoning was to prove unfounded over time. Many of the Bengali clients while requesting detoxification on an outpatient basis failed to stay 'stable', on the detoxification regime and began to use heroin 'on top' . All the Bengali clients who completed a detoxification programme relapsed within a fortnight or earlier after their medication regime had finished. In contrast, the White/European clients showed a greater ability to stay opiate free after the medication regime finished, despite having more problematic presentations with poly drug use. **Therefore, the ethos of 'catching their habits quickly' was misplaced.**

Devil's in the detail

So why the big difference? On reflection, it was felt the clinical team did not pay enough attention to key details while making an assessment. In particular, they failed to address family background and support, motivation and at what stage and where the user was prepared to stay 'clean'.

Identifying these key factors during assessment is crucial if an outpatient detoxification regime is to work. **In fact, it is felt the current Bengali population emerging for treatment are being 'set-up to fail'.**

More credence also needs to be given to the influence of the family of Asian service users and their prominence in his or her decision-making process. The Bengali interviewees told us that their families were influential in them accessing a detoxification programme. In hindsight the respondents said they were not ready for this treatment, admitting that a stabilization package with methadone was more suitable.

From the clinic's point of view, it emerged that the Bengalis and their families had a very 'medical' model way of thinking about substance misuse, thereby ignoring important psychological aspects.

What is clearly needed is for services to change existing practices to better accommodate factors that can affect and motivate Asian clients. Services like the Margerete Centre therefore had to make their assessment forms and clinical approaches more appealing and effective to a wider group of clients. In other words to accommodate 'new' emerging groups an element of 'fine-tuning' is required to make their assessment and provision culturally responsive.

Family fortunes

As a result of these findings, changes to the assessment process at the Centre were put in place. This meant re-designing the assessment form to incorporate a section on family and aspirations for the client. There is also an option when the client is in treatment, if consent is given, for the family to be included in the first session. This allowed the service workers to explain the practical ways treatment services can help the user and possibly the family. The result of these changes is a vast improvement in the assessment and treatment of all clients.

Ultimately, the challenge is now for all services is to find new ways of accommodating 'new' emerging groups into their existing assessment/clinical procedures and to improve their quality of care and never assume drug users using heroin are a homogenous group.

Jeff Fernandez,
Specialist Nurse, Alcohol/Drugs, Islington PCT

References

Bashford, J, Buffin J, Patel K, *Community Engagement: (Report findings) The findings:* University of Central Lancashire (Dept. of Health) 2003.

Paper review

Psychological and social sequelae of cannabis and other illicit drug use by young people: a systematic review of longitudinal, general population studies

John Maclead, Rachel Oakes, Alex Copello, Illana Crome, Matthias Egger, Mathew Hickman, Thomas Oppenkowski, Helen Stokes-Lampard and George Davey Smith

The Lancet, Vol. 363 pp. 1579-1588, 2004

This paper undertakes a systematic review between drug use in young people and its association with several types of psychological and social harm.It finds that cross-sectional evidence cannot clarify questions of causality and that longitudinal or interventional evidence is needed. The available evidence does not strongly support an important causal relation between cannabis use by young people and psychological harm, but cannot exclude the possibility that such a relation exists. Better evidence is needed.

It is great to read a paper that is clear, informative and helps you think about your assumptions and practice – I will be recommending this one to be added to the papers to read on Part 2 of the Certificate course

Review by Chris Ford

One hundred alcoholic doctors: A 21-year follow up

Alcohol and Alcoholism, Vol. 37, No 4, pp. 370-374, 2002

G. Lloyd

This is an intriguing study. Intriguing not only because it is a long and rare study for a single cohort with alcohol dependency, but also because the cohort is made up of members of our own profession.

The North West Doctors and Dentists Group (NWDDG) was set up in 1980 to help members with substance misuse problems. The group has no prescriptive therapeutic role, and sees itself as an adjunct to other abstinence self-help groups. The study follows-up the first one hundred members of the group over an average of 17 years.

It presents some interesting statistics. Twenty-four people had died from either suicide or diseases directly attributable to alcohol such as GI haemorrhage and liver failure, and there were eight cases of oral or oesophagopharyngeal cancer.

On the brighter side, 51 were abstinent and a further 19 had died of incidental causes while being abstinent, making a total of 70 'in recovery', with a mean duration of abstinence of 17.3 years. There were the expected cases of early relapse with a close correlation of recovery with attendance at Alcoholics Anonymous (AA) meetings. Twenty-nine are still working as doctors.

This is a fascinating piece of work that supports (among other things) that durable abstinence is achievable, and that AA has a demonstrable and beneficial effect. It also demonstrates the high mortality associated with alcoholism, and that oropharyngeal cancer may be more common than was thought in those who drink heavily. It is also a unique chance to look into the often- private lives of a very public profession.

Review by Dr Gordon Morse, GP South West England Regional Lead

Care of drug users in general practice.

Berry Beaumont (ed.)

London: Radcliffe Medical Press, 2nd edition 2004.

My expectations for the 2004 revised edition of this book were very high and I was not disappointed. Berry Beaumont has edited yet another excellent reference for GPs.

She has productively expanded the book's scope with four original and new chapters. There are new sections covering the homeless, drug-using parents and BME issues, plus a reorganization of chapters on opiate maintenance and detoxification. The style is easy to digest with better referencing and an improved type layout.

The book brings together quality contributions from 24 leading players in the field and is an obvious choice for GPs undertaking training and others involved in primary care-based treatment.

The comprehensive nature of this work is its greatest strength. It authoritatively covers the essentials for a complete beginner, yet it is still a refreshing read for those of us who have been around for a while.

It is lacking only in two areas. Firstly, there needs to be more input from the pharmacist's view (for example, needle exchange, supervised consumption and ensuring prescriptions for CDs are correctly written). Secondly, nothing is said about the evolving research base, such as the NTORS study.

The book has many excellent moments. I really enjoyed Alan Joyce's chapter incorporating the thoughts of service users – something so often missing from training activity yet such a crucial perspective. Similarly, Vivienne Evans' (the Chief Executive of ADFAM) section on families and carers made for good and essential reading.

Gordon Morse's chapter on opiate detoxification made for a balanced account, blending thinking from the abstinence model with useful prescribing details.

There is also an informative chapter on the wider picture of shared care from the SMMGP team – where would we be without their invaluable support?

The final chapter by Linda Harris is probably one of the most important as it discusses our greatest challenge – to demonstrate good quality of care with drug users.

I thought this area of CPD and appraisal was approached with realistic enthusiasm and hope it will inspire busy clinicians to make use of the Clinical Governance process in a positive way.

Review by Dr Charlie Lowe
GP Specialist in Substance Misuse and Plymouth PCT lead on Drugs

Dr Fixit - How can I help this young Asian heroin smoker?

Dear Dr Fixit

Imran, a young man of 20 years of Asian decent came to see me with his father. He was asking for help with his drug problem. He has been smoking heroin for the past nine months, currently about ¼ gram a day, usually split into three to four smokes a day. For the first three months of use he smoked only at weekends with his peers. He is now finding that if he doesn't smoke he gets withdrawal symptoms.

He wants to stop but feels he needs help. His father wants to take him to India to stop using. Imran was born in the UK but has visited India many times. He is keen to continue his studies at university while dealing with his problem and wants help from me. I would like to help and feel very confident about maintenance prescribing but am unsure what the best options are for this patient. Can you help?

Dr Fixit says,

The first question to ask is, does anything change because he is of Asian decent? There may well be cultural issues, which I will now try to address, but language problems are not present with Imran and his family.

On the whole therefore, the key issues are:

- He is giving a clear history of dependency.
- He has come with his father – how knowledgeable is the father about drugs in general and heroin in particular?
- The father is supportive – ensure he understands about opioid dependency, how to access you again if he has doubts or concerns about how treatment is going (with the son's permission of course).
- Imran smoked with peers at weekends at first. How close is their relationship now – can he avoid them at all?
- Are his peers in treatment? If not, it is worth saying that door to treatment is open to them too, suggesting that he might like to mention this to them, reminding him that this will ultimately help him too.
- Don't forget to offer Hepatitis A and B vaccination, even if only smoking he is potentially at risk of BBV if he starts injecting in future. Remember that India has endemic Hep B.

There are anecdotes regarding patients being 'sent' back to the Asian subcontinent by their distressed relatives, only to find that drugs are far cheaper there; some pharmaceutical versions are available over the counter in pharmacies and a few patients may return with a worse habit than when they left.

He, his father and the rest of his family may feel shame, like so many other families, which can bring out strong emotions, such as anger and guilt. These factors may well be influential in his decision making regarding treatment choices. Both father, patient and family may feel that stopping all drugs is the only solution but this may not be the only or correct option for Imran. If these can be aired he may feel more able to address the treatment packages you are offering. It is necessary for his father to understand and embrace the *principles* of the treatment offered so that he does inadvertently jeopardise it for whatever reason. A home visit is usually appreciated and is an effective way to convey harm minimisation principles to the whole family.

If the drug problem is not discussed openly in his community, supervised consumption may be difficult. You may have to consider whether the family reputation may be at stake, and some patients work long hours, making compliance difficult.

Imran and his father are requesting a detox, which is understandable with Imran's history. There is evidence however that even with uncomplicated and short drug profiles this may not prove the most effective approach (See this issue's 'Cultural considerations' on page 8). You should spend time explaining the nature of drug use as a chronic relapsing condition and the principles of maintenance so they make an informed choice. Time is also needed to explain the advantages and disadvantages of buprenorphine versus methadone

If detox is chosen it should never be stand-alone and needs to include a range of support including talking to you as his GP, relapse prevention groups and in-patient rehabilitation. Detoxification is more difficult than maintenance so don't be afraid to ask for help from your local specialist service.

You both may decide the treatment of choice is a fairly rapid titration with supervised buprenorphine up to a stable dose of perhaps between 12-16mgs with family support during the induction period. Support from an intensive key-worker and maintenance therapy until he is ready to reduce will also help. Then start the reduction at a speed he can manage and continue key working to ensure coping and that there are no serious new issues emerging with drug-free lifestyle.

After a full assessment or during treatment, many things could emerge which affect this choice. These can include disclosures of worse dependency than originally presented; revealed dependency in other family members once the son is speaking in confidence; a 'quick fix' family solution such as the India trip; or a DIY home detox occurring in the middle of treatment.

Maintaining engagement with Imran is crucial as detox is rarely a quick and easy solution in itself. Support him to make informed choices at all times and try to keep his family informed and on board with treatment.

Answer by Dr Susi Harris, Clinical Lead in Substance Misuse Calderdale Substance Misuse Service

Dr Fixit - Is buprenorphine maintenance right for my patient?

Dear Dr Fixit,

Pauline aged 36 years, came into treatment with me two months ago. She has been injecting about 1gm of heroin a day for about 14 years. She occasionally uses crack and benzodiazepines, particularly when heroin is sparse. She drinks lager, about 14 units a week.

She has never been in treatment before and is keen to stop all drugs. She feels she can do this in the community using buprenorphine, like a friend has done. She does not want to attend a rehabilitation centre as she believes this will disrupt the care of her two children. She is a single mum.

She initially stabilised on 20mgs of buprenorphine and stopped using all other drugs except cannabis. She then started to reduce her dose and continued to not use on top of her prescription until she reduced to 6mgs. Since then she has gone back to injecting heroin.

She is really frustrated and feels that she has failed. She has also found out she is hepatitis C positive – though her liver function tests are normal. I have discussed this with her, including her options.

She would like to try buprenorphine maintenance, as she likes the drug. I feel confident about using buprenorphine for detoxification but don't have any experience with its use in maintenance. Is this her best option? How should I proceed and what is the best dose for her? What are the implications for her hepatitis C, if any?

Dr Fixit says,

Buprenorphine is a safe and effective medication for maintenance treatment – indeed most of the research with buprenorphine has been as a maintenance medication. The general principles of buprenorphine maintenance are the same as for methadone maintenance – treatment is most likely to be effective when:

(a) adequate doses of medication are used;

(b) treatment is long term (generally years, allowing adequate time for the patient to make appropriate lifestyle changes);

(c) there is a good therapeutic relationship between the patient and service providers, and;

(d) the patient utilises a range of psychosocial and medical resources according to their needs.

3For this woman, 6mg buprenorphine appears inadequate to prevent her from using heroin. I would discuss her options with her, including the option of transferring to methadone, or continuing with buprenorphine for maintenance treatment. Discuss how an increase in buprenorphine dose would reduce her cravings to use heroin, and indeed block (or at least reduce) the effects of any heroin used on top. I would suggest rapid dose increases (for example from 6-12mg and then 16mg on consecutive days).

Unlike methadone treatment, dose increases can happen quite rapidly. It is likely that she would respond well on 16 mg buprenorphine, however if she continued to use heroin, had cravings or features of withdrawal discomfort, I would not hesitate in increasing her dose to 20mg or 24mg as required. Research indicates that higher doses of buprenorphine (such as 16mg or more) are generally more effective than lower doses.

With regards to her hepatitis C, given that she is asymptomatic and has normal liver function test results, I would suggest monitoring her at regular intervals (say six-monthly). There is no evidence linking normal buprenorphine doses with liver disease or deterioration in hepatic function.

Answer by Dr Nicholas Lintzeris, Senior Lecturer at National Addiction Centre, Institute of Psychiatry, Kings College London

PharMAG and PharMAGazine

PharMAG was founded in 1997 by three pharmacists that recognised the need to provide and information and support network for those with a special interest in pharmacy and substance misuse. The current objectives of PharMAG are:-

1. to encourage high quality pharmaceutical Care in the area of substance misuse
2. to promote the role of pharmacy within the field of substance misuse
3. to promote inter-professional collaboration
4. to act as a source of information to others
5. to promote discussion of substance misuse and stimulate debate
6. to respond to national and local policy issues
7. to provide members with a newsletter (PharMAGazine)
8. to promote prevention of, abstention form, substance misuse as well as treatment and detoxification.

Currently we have approximately 400 members from all areas of pharmacy and from other disciplines and healthcare professions. Members are resident in the United Kingdom, Ireland, Europe, Australasia and the Caribbean. Since 1997 the Steering Committee has responded to numerous consultation documents form the Medicines and Health Care products Regulatory Agency, the Department of Health, the Home Office and the Royal Pharmaceutical Society. PharMAGazine is normally published quarterly. Back copies of PharMAGazine as well as an application form for membership of PharMAG can be obtained from Kay Roberts, Chairman and Membership Secretary C/0 Pharmacy Department, Leverndale Hospital, 510 Crookston Road,Glasgow G53 7TU 0141 211 6478

kay.roberts@glacomen.scot.nhs.uk

Bulletin Board

Crack training – don't miss out

Due to continuing demand, the RCGP Drug Certificate Programme, SMMGP and RCGP Sex Drugs and HIV Task Group are pleased to announce their fourth set of crack cocaine training for primary care staff.

The training is in two parts. Day one focuses on the practicalities of working with crack cocaine users in primary care and is lead by members of the 'Crack Squad' who have experience in using the drug. Day two tests the deliverability of the interventions described in the former session and is lead by GPs peer tutors. Day two mainly consist of small group work of 'how' to do it, including a session on crack use among people receiving substitute prescribing.

In Manchester, part one is on Wednesday 27th October 2004 and part two on Wednesday 15th December 2004. In London part one is on Tuesday 18th January 2005 and part two on Tuesday 15th February 2005.

Please complete the flyer enclosed with this Network or apply to:
Monique Tomlinson, PO Box 36646, London SE1 9ZT, phone/fax: 020 7928 9152 or e-mail: moniquetomlinson@wdi.co.uk

Latest buprenorphine guidance out now

A new edition of the RCGP/SMMGP Buprenorphine guidance is now available. This revised, second edition brings out the latest new evidence and updated practice: rapid induction, using for maintenance (see article in this edition) and using with liver problems.

We have also arranged two training days to discuss the new guidance. These are on Tuesday 21st September 2004 in London and Tuesday 5th October 2004 in Newcastle.

To participate in training please complete the enclosed flyer or contact Terri Myers at RCGP, National Drug Misuse Training Programme, Frazer House, 32-38 Leman Street, E1 8EW, telephone 020 7173 6090/6093 or e-mail: tmyers@rcgp.org.uk.

For copies of the guidance please contact SMMGP's Mark Birtwistle (see our contact details below) or Jo Betterton, RCGP NDMTP, 32-38 Leman Street, E1 8EW, 0207173 6093 or jobetterton@rcgp.org.uk

NDTMS forms and NTA codes now online

Reference data and codes used to monitor drug treatment in England with NTA and the National Drug Treatment Monitoring System (NDTMS) are now available online.

All drug use should be notified to NDTMS, now run by the NTA. For those seeing small numbers of drug users, this is currently done using paper forms. For larger numbers (more than 20 patients) this should be done electronically.

The data is to facilitate monitoring of drug trends in areas and is anonymous. It is essential that a form is completed for each patient in treatment with you and a follow-up form on an annual basis. For more details visit
www.nta.nhs.uk/programme/national/monitoring.htm#reference

Designer Treatment: meeting the needs of the patient'

Our 9th conference a success – planning for the 10th!

An impressive 91% of delegates scored the 9th Conference of Managing Drug Users in General Practice as good to excellent so it seems that the conference continues to get thumbs up all round! Of particular mention in the plenaries were 'The Holy Grail of Abstinence' by Gordon Morse, 'Talking to patients' by Steve Rollnick and 'Working with problematic families' by Rhoda Emlyn Jones. The user facilitated workshops on designer treatment and the papers sessions were new additions and both extremely well received.

The consensus statement of the conference was:

- **This conference reasserts that the involvement of users is essential in designing services that meet their needs.**
- **We welcomed the increased training opportunities provided by the new part 1 RCGP certificate course.**
- **We regret that one of the effects of the new GP contract is that restrictions have been placed on the number of practices funded to provide treatment services for drug users.**
- **This conference calls for Departments of Health to exert pressure on the Local Health Boards to provide primary care services for drug users in every area.**

The 10th Conference will be held at the West London Convention Centre, Hammersmith, Thursday 28 & Friday 29 April, 2005 title *'10 Years On: looking back; moving forward'*

Release Drugs University IV Conference

This year's Release conference will examine the increasingly important theme of drugs, the law and human rights. There will be a wide variety of thought provoking presentations by leading international experts. There should be something for all, especially those from the field of law enforcement or human rights, drug treatment or politics. 'Drugs – The Politics, Philosophy and Economics' is on Friday 28th January 2005 at RIBA, London. For further details please see our website: www.release.org.uk, or contact Monique Tomlinson on Tel/fax: 020 792 9152 or e mail: moniquetomlinson@wdi.co.uk

3rd National Drug Treatment Conference

This major annual conference will yet again bring practitioners from all disciplines and drug users together with speakers from the UK and across the world to discuss key issues in drug treatment. To be held on 21st and 22nd February 2005 at the Victoria Park Plaza Hotel, London. For full details please see our website: www.exchangesupplies.org, or contact Monique Tomlinson, Tel/fax: 020 792 9152 or e mail: monique@exchangeconferences.org

NETWORK Production

Managing Editor:
Jean-Claude Barjolin

Advisory Editor:
Dr Chris Ford

Consultant Editor:
Gary Hayes

Associate Editors:
Jim Barnard
Christina McArthur
Kate Halliday
Annas Dixon

Contact:

Mark Birtwistle,
Management Support Officer,
SMMGP,
c/o The Edge, 27-35 Edge Lane,
Stretford,
Manchester
M32 8HN

Tel: 0161 866 0126

email: mark@smmgp2.demon.co.uk
website: www.smmgp.co.uk

NETWORK NEWSLETTER
IS SPONSORED BY
SCHERING-PLOUGH LTD

Network ISSN 1476-6302

SMMGP works in partnership with

Trafford Substance Misuse Services

National Treatment Agency for Substance Misuse